AWAKEN
CHIROPRACTIC

Today's Date _____/_____/____

PEDIATRIC HISTORY FORM
(12 & UNDER ONLY)

PATIENT DEMOGRAPHICS HR#:_________________

Childs Name____

Date of Birth _____/_____/______ Age: _____ Gender: M / F

Birth Height: _______ Birth Weight: _______ Current Height: ______ Current Weight: _____

Address ____

City _____________________ State _____ Zip __________ Phone (Home) ________________________

Guardian #1 Name: _________________________ DOB____/____/____ Cell Phone: _______________

E-mail: ____ SS#: _____________________

Guardian #2 Name: _________________________ DOB ____/____/____ Cell Phone: _______________

E-mail: ____ SS#: _____________________

Pediatrician/Family MD _____________________________________City/State ____________________

Last Visit: ____/____/____ Reason for visit:____

Who is responsible for this bill? ____

☐ Other *(please explain)*: ____

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____ Specific Condition

Please explain: ____

*If your child is experiencing **Pain/Discomfort** please identify **where and for how long***

____

____

1. **When did the** Problem first begin? Date ___/___/___ __Unknown __Gradual __Sudden
2. **Ever had** this problem **before**? ___ No ___Yes If yes, when? _________________________________
3. Any **bowel or bladder** problems since this problem began?: If yes, describe:

____

4. Any problems preforming daily activities? If yes, what: ______________________________________
5. Have you seen any **other doctors** for this problem? ___No ___Yes If yes, who?

____

6. How long ago were they treated? _____Days _____Weeks ______Months _____Years
7. What were the results of past treatment? ____
8. How is this problem **NOW?:**

☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

9. Please list any **medication taken** for this problem: ____

10. Has your child ever sustained an injury playing organized sports? ___ No ___ Yes - If yes; please explain:

    ____

    ____

11. Has your child ever sustained an injury in an auto accident? ___ No ___ Yes If yes; please explain:

    ____

    ____

12. **Briefly explain your child's birth**. Were there any interventions (C-section, forceps, etc)? Any complications? Labor time? ____

    ____

    ____

HAS YOUR CHILD EVER SUFFERED FROM: *Check all that apply*

☐ Headaches ☐ Orthopedic Problems ☐ Digestive Disorders ☐ Behavioral Problems
☐ Dizziness ☐ Neck Problems ☐ Poor Appetite ☐ ADD/ADHD
☐ Fainting ☐ Arm Problems ☐ Stomach Aches ☐ Ruptures/Hernia
☐ Seizures/Convulsions ☐ Leg Problems ☐ Reflux ☐ Muscle Pain
☐ Heart Trouble ☐ Joint Problems ☐ Constipation ☐ Growing Pains
☐ Chronic Earaches ☐ Backaches ☐ Diarrhea ☐ Asthma
☐ Sinus Trouble ☐ Poor Posture ☐ Hypertension ☐ Walking Trouble
☐ Scoliosis ☐ Anemia ☐ Colds/Flu ☐ Sleeping Problems
☐ Bed Wetting ☐ Colic ☐ Broken Bones ☐ Fall off swing
☐ Fall in baby walker ☐ Fall from bed or couch ☐ Fall from crib ☐ Fall down stairs
☐ Fall off bicycle ☐ Fall from high chair ☐ Fall off slide
☐ Fall from changing table ☐ Fall off monkey bars ☐ Fall off skateboard/skates
☐ Allergies to____
☐ Other: ____

I understand that I am directly and fully responsible to **Awaken Chiropractic** for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

____ _____________________

Parent or Legal Guardian's Signature Date

____ _____________________

Doctor's Signature Date

QUADRUPLE VISUAL ANALOGUE SCALE

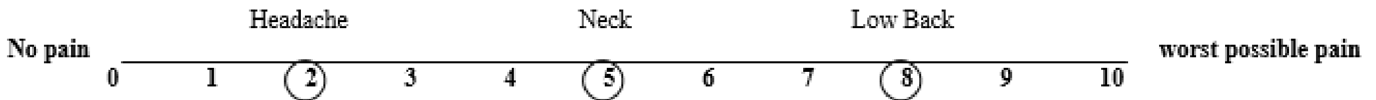
Patient Name ______________________________ Date ____________________

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

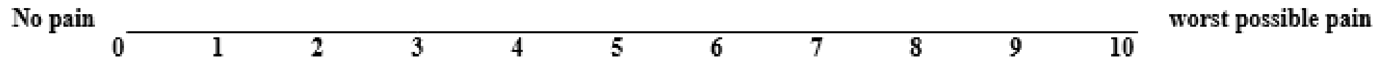
Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

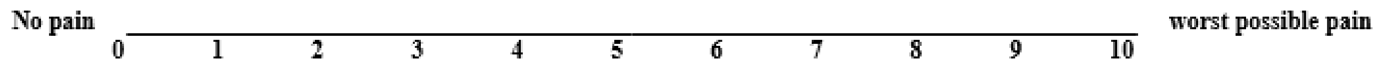


1 – What is your pain RIGHT NOW?

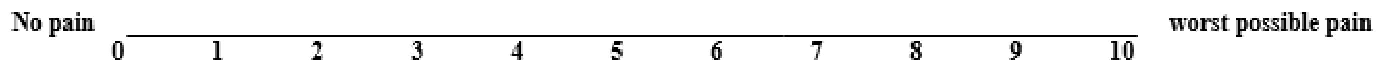
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



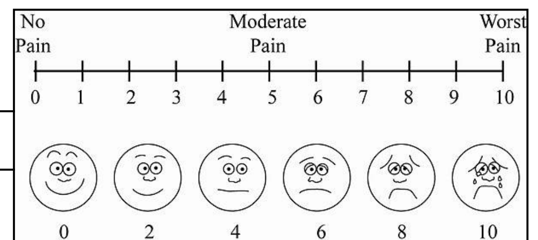
4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

____

____



____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.